FORM B

REASONABLE TESTING ACCOMMODATIONS DISABILITY DOCUMENTATION

(To be completed by a physician or licensed professional for all applicants)

Physician or Licensed Professional

Name:_____

Title:_____

License/Certification Number:_____

Address:_____

Telephone Number:_____

Applicant Name:_____

Please describe your credential(s) which qualify you to diagnose and/or verify the applicant's disability and to recommend an accommodation: _____

_____

_____

What is the specific diagnosis, condition, or physical impairment that requires testing Accommodations?

_____

_____

Briefly describe the nature of the condition and describe how this condition affects the Applicant.

_____

Current Treatment consisted of: _____

_____

Last date of treatment of consultation with applicant:_____

Length of treatment with applicant: _____

Is this a permanent condition/disability? YES_____ NO_____

If no, when is the condition/disability likely to abate?_____

In what way does the condition/disability affect the applicant's ability to read, write and/or concentrate for extended periods of time? _____

_____

Based on this person's disability and your diagnosis, what testing accommodations would you recommend?

_____Regular print test book
_____Additional Testing time
_____A reader
_____Sign-language/Interpreter
_____Rest periods during time session
_____-per session.
_____Test room and restrooms accessible by wheelchair
_____Other_____

Please explain how the recommended accommodation relates to the disability

_____

I certify that all the information on this form is true and correct to the best of my knowledge.

_____

Signature of Physician/Licensed Professional **Name (print)** **Date**